



Office of Registration and Records
 615 7th ST SW
 Rochester MN 55902
 507.328.4200 fax: 507.281.6086

OFFICE USE ONLY

Today's Date	ESL NCC	LANG	LLA	Enrollment Date	Student ID	Res. Dist.	Grid #
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Student's Legal Last Name	Student's Legal First Name	Student's Legal Middle Name	Gender <input type="checkbox"/> F <input type="checkbox"/> M	Date of Birth: (month/day/year)	Has this student or any siblings ever attended any: Rochester School? <input type="checkbox"/> Yes <input type="checkbox"/> No Minnesota School? <input type="checkbox"/> Yes <input type="checkbox"/> No		
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Student Address	Lot/Apt#	City	State	Zip	Phone: (Check one.) <input type="checkbox"/> Home <input type="checkbox"/> Cell	TRANSPORTATION SERVICES <input type="checkbox"/> Yes If eligible, will this student use transportation services? <input type="checkbox"/> No	
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Student lives with: <input type="checkbox"/> Both Parents <input type="checkbox"/> Father <input type="checkbox"/> Other (Check ALL that apply.) <input type="checkbox"/> Mother <input type="checkbox"/> Alone	Last Name of Other	First Name of Other	Relationship to student:
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LEGAL GUARDIAN #1				LEGAL GUARDIAN #2			
Relationship to Student:				Relationship to Student:			
Legal Last Name	Legal First Name	Legal Middle Name	Gender <input type="checkbox"/> F <input type="checkbox"/> M	Legal Last Name	Legal First Name	Legal Middle Name	Gender <input type="checkbox"/> F <input type="checkbox"/> M

Address (if different that student.)	Lot/Apt#	City	State	Zip	Address (if different that student.)	Lot/Apt#	City	State	Zip
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Primary Phone (Check one.) <input type="checkbox"/> Home <input type="checkbox"/> Cell	Work Phone	Primary Phone (Check one.) <input type="checkbox"/> Home <input type="checkbox"/> Cell	Work Phone
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Email address	Email address
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Guardian #1 Employer	Guardian #2 Employer
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EMERGENCY CONTACT INFORMATION I give permission to emergency contact to pick up student from school if the school is in unable to contact Legal Guardian(s). Yes

Contact Last Name	Contact First Name	Phone	Relationship to student
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STUDENT SUPPORT SERVICES INFORMATION* *Please complete questions on reverse side.		ETHNIC/RACE Check one.	NEW U.S. RESIDENT INFORMATION	
<input type="checkbox"/> Autism Spectrum Disorder	<input type="checkbox"/> Deaf and Hard of Hearing	<input type="checkbox"/> American Indian	Date student entered the U.S.	
<input type="checkbox"/> Developmental Cognitive Disorder-Mild	<input type="checkbox"/> Developmental Cognitive Delay-Severe	<input type="checkbox"/> Asian	From which country?	
<input type="checkbox"/> Emotional Behavioral Disorder	<input type="checkbox"/> Other Health Disorder	<input type="checkbox"/> Hispanic	<input type="checkbox"/> Refugee	Date started school :
<input type="checkbox"/> Physical Impairment	<input type="checkbox"/> Specific Learning Disability	<input type="checkbox"/> Black	<input type="checkbox"/> Immigrant	
<input type="checkbox"/> Visual Impairment	<input type="checkbox"/> Traumatic Brain Injury	<input type="checkbox"/> White	Have you moved to this school district within the last 3 years for temporary or seasonal agricultural or fishing work (migrant)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Speech Language Impairment	<input type="checkbox"/> Early Childhood Special Education-ECSE			
Does your student require special transportation? <input type="checkbox"/> Wheelchair <input type="checkbox"/> Car-Seat <input type="checkbox"/> Seizures <input type="checkbox"/> Other				

Does your student receive special accommodations at a school for a disability (504 Plan)? <input type="checkbox"/> Yes If yes, Please provide a copy for our records. <input type="checkbox"/> No	OFFICE USE ONLY	REQUEST FOR HEALTH AND EDUCATIONAL RECORDS
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Please list, in order of birth, ALL children in this family who are school age or younger— INCLUDING THE STUDENT YOU ARE ENROLLING							School Year	School most recently attended by student:	
Last Name	First Name	Middle Name	Gender	DOB	Birth City/State	School Code	Grade	School Name	
1.								School Address	
2.								City	State Zip
3.								Phone	Last date of attendance
4.								Parent/Guardian Signature	Initials of office personnel
5.									

TENNESSEN NOTICE

All Minnesota school districts are part of a state-wide computer reporting system which uses personally-identifiable information to record information about your child. This information is, in turn, provided to the Minnesota education department. This department is required by law to collect and store information about each pupil, each staff member, and each educational program. **Therefore, we ask that you, the parent, provide your child's personally-identifiable information below and marked with * on the front side of this form. The education department uses this information to determine how much money your school district receives from the state and federal government. This information is also used to judge the quality of the state's educational programs, to improve instruction, to follow trends in student enrollment, and to track student participation in various programs.

Your child's school district will share this information with the education department. The education department will share the information with the Department of Human Services to allocate additional funding and improve instruction. As a parent, you do not have to provide the personally-identifiable information for your child. However, if you choose not to provide the information, services may not be provided from the beginning of the child's enrollment (i.e., special education or ESL service).

SPECIAL EDUCATION QUESTIONS

At your previous school, how much time did your child spend each day in a special education classroom? Please check one.

- 1 hour or less Less than half a day Most of the school day

List the Name and phone number of the last special education teacher :

Teacher's Name

Phone

Do you have a copy of the current IEP and most recent Evaluation/Assessment report? Yes No If **YES**, please provide those to our District as soon as possible.

Ethnicity/Race

In accordance with state and federal regulations, we are required to collect and report student ethnicity and race using the two part question below. Please complete this form and submit with registration materials.

Today's Date: _____

Student Name (last name, first name) _____

Date of Birth: _____

Part A. **Is this student Hispanic/Latino?** (Choose only one)

No, not Hispanic/Latino

Yes, Hispanic/Latino (A person of Cuban, Mexican, Puerto Rican, South or Central American or other Spanish culture or origin, regardless of race.)

The above part of the question is about ethnicity, not race. No matter what you selected above, **please continue to answer the following** by marking one or more boxes to indicate what you consider your student's race to be.

Part B. **What is the student's race?** (choose one or more)

American Indian or Alaska Native (A person having origins in any of the original peoples of North or South America including Central America, and who maintains a tribal affiliation or community attachment.)

Asian (A person having origins in any of the original peoples of the Far East, Southeast Asia or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand and Vietnam.)

Black or African American (A person having origins in any of the black racial groups of Africa.)

Native Hawaiian or Other Pacific Islander (A person having origins in any of the original peoples of Hawaii, Guam, Samoa or other Pacific Islands.)

White (A person having origins in any of the original peoples of Europe, the Middle East or North Africa.)

Residency Information*

Is the student's current address a temporary living arrangement? Yes No If yes, continue:

Is this temporary living arrangement due to loss of housing or economic hardship? Yes No

Does the student lack a fixed, regular, adequate nighttime residence? Yes No

*Residency information is used for the purpose of determining eligibility for services under federal laws for providing education to students in temporary living situations.

Minnesota Language Survey

Minnesota is home to speakers of more than 100 different languages. The ability to speak and understand multiple languages is valued. The information you provide will be used by the school district to see if your student is multilingual. In Minnesota, students who are multilingual may qualify for a Multilingual Seal upon further assessment. Additionally, the information you provide will determine if your student should take an English proficiency test. Based upon the results of the test, your student may be entitled to English language development instruction. **Access to instruction is required by federal and state law. As a parent or guardian, you have the right to decline English Learner instruction at any time.** Every enrolling student must be provided with the Minnesota Language Survey during enrollment. Information requested on this form is important to us to be able to serve your student. Your assistance in completing the Minnesota Language Survey is greatly appreciated.

Student Information	
Student's Full Name: (Last, First, Middle)	Birthdate or Student ID:

	Check the phrase that best describes your student:	Indicate the language(s) other than English in space provided:
1. My student first learned:	<input type="checkbox"/> language(s) other than English. <input type="checkbox"/> English and language(s) other than English. <input type="checkbox"/> only English.	
2. My student speaks:	<input type="checkbox"/> language(s) other than English. <input type="checkbox"/> English and language(s) other than English. <input type="checkbox"/> only English.	
3. My student understands:	<input type="checkbox"/> language(s) other than English. <input type="checkbox"/> English and language(s) other than English. <input type="checkbox"/> only English.	
4. My student has consistent interaction in:	<input type="checkbox"/> language(s) other than English. <input type="checkbox"/> English and language(s) other than English. <input type="checkbox"/> only English.	

Language use alone does not identify your student as an English learner. If a language other than English is indicated, your student will be screened for English language proficiency.

Parent/ Guardian Information	
Parent/Guardian Name (printed):	
Parent/Guardian Signature:	Date:

* All data on this form is private. It will only be shared with district staff who need the information to best serve your student and for legally required reporting about home language and service eligibility to the Minnesota Department of Education. At the district and at the Minnesota Department of Education, this information will not be shared with other individuals or entities, except if they are authorized by state or federal law to access the information. Compliance with this request for information is voluntary.

STUDENT INFORMATION

Name _____ DOB / / Gender M F
 School _____ Grade _____ Parent/Guardian Name _____
 Phone # _____ Phone # _____ Email _____

HEALTH HISTORY Check all conditions your child currently has or has been treated for in the past

CONDITION	EXPLAIN
<input type="checkbox"/> Diabetes	
<input type="checkbox"/> Seizures	
<input type="checkbox"/> Allergies	
<input type="checkbox"/> Asthma	
<input type="checkbox"/> Lung/Respiratory Disease	
<input type="checkbox"/> Heart/Cardiovascular Conditions	
<input type="checkbox"/> Head Injury/Concussion	
<input type="checkbox"/> Behavioral or Emotional Difficulties	
<input type="checkbox"/> Neurological Disorders	
<input type="checkbox"/> Attention Disorders (ADD,ADHD)	
<input type="checkbox"/> Mental Health Conditions (e.g., anxiety, depression)	
<input type="checkbox"/> Fainting Spells and Dizziness	
<input type="checkbox"/> Kidney/Bladder Conditions	
<input type="checkbox"/> Ear/Eyes/Nose/Sinus Problems	
<input type="checkbox"/> Muscle or Bone Conditions	
<input type="checkbox"/> Abdominal/Stomach/Digestive Problems	
<input type="checkbox"/> Migraines or Severe Headaches	
<input type="checkbox"/> Food Restrictions/Special Diet	
<input type="checkbox"/> Skin Conditions	
<input type="checkbox"/> Mobility Problems or Activity Restrictions	
<input type="checkbox"/> Learning Problems	
<input type="checkbox"/> VISION CONCERNS	Glasses/Contacts <input type="checkbox"/> Yes <input type="checkbox"/> No For: Last professional eye exam / / Results:
<input type="checkbox"/> HEARING CONCERNS	Hearing Device <input type="checkbox"/> Yes <input type="checkbox"/> No Type: <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both ears
<input type="checkbox"/> List any other medical conditions:	

MEDICATIONS List all prescription, over-the-counter, and medications taken as needed (e.g., EpiPen, inhalers, pain relievers)

Medication	Dose	Frequency	Reason

Would you like to schedule a conference with the licensed school nurse to discuss a particular health concern? Yes No
 Indicate your concern(s): _____

The information you provide will only be shared with school staff who require access to this information to meet your child's health and safety needs while at school. Not providing complete and accurate information may result in an incomplete health and safety plan for your child.

 Parent/Guardian signature _____
Date

Where is your child this year?

Rochester Public Schools would like to know how many children have participated in an early childhood program in the year before kindergarten and if so, what type of program(s) they have attended. No individual children will be identified in these reports. Only group reports will be generated.

Child's Last Name	Child's First Name	M.I.	Date of Birth

Check all that apply:

PRESCHOOL

Rochester Public Schools	
<input type="checkbox"/> PAIRR Readiness Preschool (Explorers, Voyagers, Adventurers, Pathfinders, Trailblazers)	
<input type="checkbox"/> Rochester Family Literacy (Hawthorne)	
<input type="checkbox"/> Early Childhood Special Education (ECSE)	Site: _____

Families First of Minnesota (Formerly Child Care Resources & Referral)	
<input type="checkbox"/> Head Start	Site: _____
<input type="checkbox"/> School Readiness	Site: _____

Preschool Center
<input type="checkbox"/> Name: _____

OTHER
<input type="checkbox"/> Please explain: _____

How often did your child attend preschool?
<input type="checkbox"/> 1 day/week <input type="checkbox"/> 2 days/week <input type="checkbox"/> 3 days/week <input type="checkbox"/> 4 days/week <input type="checkbox"/> 5 days/week
How long was their preschool day?
<input type="checkbox"/> Full Day <input type="checkbox"/> Half Day

CHILD CARE

<input type="checkbox"/> Home with parent/guardian/nanny
<input type="checkbox"/> In-home care with a child care professional
<input type="checkbox"/> In-home care with a neighbor, friend, or family member
<input type="checkbox"/> Child Care Center
<input type="checkbox"/> Other: _____

OTHER QUESTIONS

Does your preschool/child care program have a Parent Aware rating?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I don't know
Do you feel your child is ready for Kindergarten?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I don't know
I would like a parent educator to contact me about:	_____